Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH HEB
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
HARTFORD INSURANCE CO OF THE MIDWEST

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-2602-01

MFDR Date Received
April 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008"

Amount in Dispute: $8,804.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is that Carrier's position that no additional reimbursement is due to Texas Health HEB for date of service July 19, 2011."

Response Submitted by: Broadspire, PO Box 701809, Dallas, Texas 75370-1809

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2011	Outpatient Hospital Services	$8,804.24	$2,159.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
2. 28 Texas Administrative Code §133.10 sets out requirements related to billing forms and formats.
3. 28 Texas Administrative Code §133.200 sets out procedures for insurance carriers upon receipt of medical bills.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
6. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 147 – Provider contracted/negotiated rate expired or not on file.
   - 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
   - 595-004 – THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
   - 900-001 – O-DENIAL AFTER RECONSIDERATION BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.
   - 953-201 – UNSUCCESSFUL NEGOTIATION ATTEMPT.
   - W1 – Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information
   - W4 – O-DENIAL AFTER RECONSIDERATION/BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.
   - 18 – Duplicate claim/service. $0.00
   - 886 – REIMBURSEMENT NOT RECOMMENDED AS SERVICE APPEARS TO BE A DUPLICATE OF ANOTHER SERVICE BILLED ON THE SAME DATE OF SERVICE $0.00

Issues

1. Did the respondent support the insurance carrier's reasons for denial of procedure codes 23130 and 23120?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The respondent's position statement asserts that "As to HCPCS/CPT Codes 23130 and 23120, it is the carrier's position that no reimbursement would be due for these codes. Per DWC Rule 133.10(f)(2)(Y), '(2)The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: (Y) total Charge (Ub-04/field 47) is required'. Texas Health HEB did not enter a charge for either 23130 or 23120 in field 47 of the UB-04 CMS-1450 submitted for date of service 07-19-11. As a result the bill was not complete and no reimbursement would be due." Review of the submitted information finds that:
   - Per 28 Texas Administrative Code §133.200, effective May 2, 2006, 31 *Texas Register* 3544, requires, in pertinent part that "(a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions). . . . (2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall . . . (B) return the bill to the sender, in accordance with subsection (c) of this section. . . . (c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill." Review of the submitted information finds that the insurance carrier failed to return the bill to the sender as incomplete within 30 days of receipt; therefore, the respondent has not met the requirements of §133.200 and may not claim as a defense that the bill was incomplete.
   - The respondent's position statement cites a rule that did not exist or that was not in effect on the date of service in dispute. 28 Texas Administrative Code §133.10, effective May 1, 2008, 33 *Texas Register* 3443, states, in pertinent part, that "(a) Health care providers shall submit medical bills for payment: (1) on standard forms used by the Centers for Medicare and Medicaid Services (CMS); . . . (d) All information submitted on required billing forms must be legible and completed in accordance with Division instructions." On the disputed date of service, field 47 was not specified as a required data element. The amended rule cited by the respondent was not effective until August 1, 2011, 36 *Texas Register* 929, and is not applicable to bills submitted for the service date involved in this dispute.
   - For outpatient hospital services, 28 Texas Administrative Code §134.403(d) requires, in pertinent part, that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §180.2, "When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with '0' charges in the charge field." Review of the submitted medical bill finds that the health care provider has met the billing requirements of §134.403(d) and §133.10.

- Per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was submitted to support that, prior to the date the request for MDR was filed, the insurance carrier ever presented to the requestor a defense or reason for denying the disputed service based on the assertion that the health care provider did not enter a charge amount in a required field, or that the bill was incomplete. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(B); consequently, these newly raised defenses or denial reasons shall not be considered.

The Division concludes that the respondent has not supported the insurance carrier's reason for denial of the disputed services. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $14.87. 125% of this amount is $18.59. The recommended payment is $18.59.
   - Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $36.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.89. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $20.93. The non-labor related portion is 40% of the APC rate or $14.59. The sum of the labor and non-labor related amounts is $35.52. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $35.52. This amount multiplied by 200% yields a MAR of $71.04.

- Procedure code 88311 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0342, which, per OPPS Addendum A, has a payment rate of $11.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $6.62. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $6.33. The non-labor related portion is 40% of the APC rate or $4.42. The sum of the labor and non-labor related amounts is $10.75. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $10.75. This amount multiplied by 200% yields a MAR of $21.50.
- Procedure code 23410 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,259.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,955.58. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $1,869.73. The non-labor related portion is 40% of the APC rate or $1,303.72. The sum of the labor and non-labor related amounts is $3,173.45. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,173.45 divided by the sum of all S and T APC payments of $4,281.16 gives an APC payment ratio for this line of 0.741259, multiplied by the sum of all S and T line charges of $4,442.00, yields a new charge amount of $3,292.67 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $3,173.45. This amount multiplied by 200% yields a MAR of $6,346.90.
- Procedure code 23130 is unbundled. This procedure is a component service of procedure code 23410 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 23120 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $2,220.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,332.50. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $1,274.00. The non-labor related portion is 40% of the APC rate or $888.33. The sum of the labor and non-labor related amounts is $2,162.33. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,081.17 divided by the sum of all S and T APC payments of $4,281.16 gives an APC payment ratio for this line of 0.252541, multiplied by the sum of all S and T line charges of $4,442.00, yields a new charge amount of $1,121.79 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service, including multiple-procedure discount, is $1,081.17. This amount multiplied by 200% yields a MAR of $2,162.34.
- Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $71.77. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $115.21. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $114.00. The recommended payment is $114.00.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.36. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $15.64. The non-labor related portion is 40% of the APC rate or $10.90. The sum of the labor and non-labor related amounts is $26.54. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $26.54 divided by the sum of all S and T APC payments of $4,281.16 gives an APC payment ratio for this line of 0.006199, multiplied by the sum of all S and T line charges of $4,442.00, yields a new charge amount of $27.54 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $26.54. This amount multiplied by 200% yields a MAR of $53.08.

5. The total allowable reimbursement for the services in dispute is $8,791.20. This amount less the amount previously paid by the insurance carrier of $6,631.76 leaves an amount due to the requestor of $2,159.44. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,159.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,159.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 30, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.